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	185332	A. BUILDING _____ B. WING _____	C 07/31/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED An Abbreviated/Partial Extended Survey investigating complaint KY00023597 was initiated on 07/29/15 and concluded on 07/31/15. Immediate Jeopardy was identified on 07/30/15 and was determined to exist on 07/26/15 with deficiencies cited at 42 CFR 483.20 Resident Assessment, F282; and 42 CFR 483.25 Quality of Care, F323 at a Scope and Severity (S/S) of a "J." Substandard Quality of Care (SQC) was identified at 42 CFR 483.25. The facility was notified of the Immediate Jeopardy on 07/30/15. On 07/26/15, Resident #1 exited the facility between 7:30 PM and 7:35 PM, without staff's knowledge. Resident #1 had been making prior statements about going home and attempting to exit through one (1) of the facility's hallway doors. Resident #1, whose mobility was per wheelchair, wheeled into the facility's kitchen, proceeded to disconnect his/her tab alarm, then stood up from the wheelchair and ambulated for approximately twenty (20) feet before exiting the facility through the kitchen exit. Resident #1 was overheard calling out "help me" by a staff member exiting the facility for a break at 7:35 PM, who found the resident lying on the sidewalk immediately outside the kitchen exit door. The staff member notified nursing staff who assessed Resident #1, called 911 and sent Resident #1 to the hospital's emergency room (ER). Resident #1 was diagnosed with a Hematoma to the right forehead at the ER and returned to the facility the morning of 07/27/15. The facility provided an acceptable credible	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/13/2015

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F 000	Continued From page 1 Allegation of Compliance (AOC) on 07/31/15, alleging removal of the Immediate Jeopardy on 07/28/15. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected on 07/28/15, prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.	F 000		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure services were provided in accordance with each resident's Comprehensive Care Plan for one (1) of three (3) sampled residents (Resident #1). (Refer to F323) On 07/26/15 Resident #1 eloped from the facility through one (1) of the facility's exit doors, after previously making statements about going home and attempting to exit the facility. Resident #1, whose mobility was mainly per wheelchair, wheeled into the facility's kitchen area, stood from the wheelchair, disabled the tab alarm, ambulated through the facility's kitchen and eloped without staff's knowledge through the kitchen exit door. Resident #1 was heard calling out "help me" by an employee exiting the facility for break at 7:35 PM. The employee found Resident #1 lying on	F 282	Past noncompliance: no plan of correction required.	

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the sidewalk outside the kitchen exit door, and alerted nurses who called 911 and sent the resident to the hospital emergency room (ER). Resident #1 was transported to the hospital ER where the resident was diagnosed with a large Hematoma to his/her right forehead and a Urinary Tract Infection (UTI).

The facility's failure to ensure each resident's written care plan interventions were implemented has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 07/30/15, and determined to exist on 07/26/15. The facility was notified of the Immediate jeopardy on 07/30/15.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 07/31/15, with the facility alleging removal of the Immediate Jeopardy on 07/28/15. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected on 07/28/15, prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

The findings include:

Review of the facility's policy titled, "Individual and Interdisciplinary Resident Care Planning", undated, revealed the implementation of a resident's care plan was an Interdisciplinary process, with the Interdisciplinary Team (IDT) responsible for meeting the needs of residents.

Review of Resident #1's medical record revealed the facility admitted him/her on 04/02/14, with diagnoses which included Alzheimer's Disease,

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Depressive Disorder, and Insomnia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 05/11/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), indicating severe cognitive impairment. Continued review of the MDS Assessment revealed the facility also assessed Resident #1 to have had wandering behavior for four (4) to six (6) days, but not daily during the assessment period.

Review of Resident #1's Comprehensive Care Plan revealed the facility had care planned Resident #1 as at risk for wandering and/or elopement. Review of Resident #1's Elopement Care Plan dated 05/11/15 revealed a goal of Resident #1 not leaving the facility without supervision. Continued review of the care plan revealed interventions which included staff engaging resident in diversional activities, offering foods and fluids, redirecting the resident when wandering near an exit door, and offering to notify the family of Resident #1 for him/her.

Review of the facility's Initial and Final Report dated 07/27/15, for an incident involving Resident #1 on 07/26/15, revealed the resident had exited the facility through the dietary department exterior door on 07/26/15. Continued review of the Report revealed Resident #1, after exiting the facility, suffered a fall on the sidewalk outside the dietary exit between 7:30 PM and 7:35 PM.

Continued record review revealed Nurse's Notes dated 07/26/15 at 7:35 PM, 7:45 PM and 7:55 PM, and 07/27/15 at 1:25 AM, which revealed Resident #1 was sent to the hospital ER on 07/26/15, diagnosed with a Hematoma and UTI

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and sent back to the facility on 07/27/15.

Interview with State Registered Nursing Assistant (SRNA) #4 on 07/29/15 at 6:50 PM, revealed she worked the evening of 07/26/15, as one of the two aides assigned to the 200 Hall, where Resident #1 resided. According to SRNA #4, on 07/25/15 and 07/26/15, Resident #1 had made comments indicating a desire to return to his/her own home. SRNA #4 stated on the evening of 07/26/15, she had observed Resident #4 wandering up and down the hallways in his/her wheelchair after supper, which the SRNA described as normal behavior for the resident. Per interview, staff interventions staff used for Resident #1, when talking about going home or wandering, included redirection by talking about other things Resident #1 liked, and providing the resident with tasks of interest to occupy his/her time. However, SRNA was unable to identify whether any interventions were attempted with Resident #1 prior to the elopement on 07/26/15, such as, engaging the resident in diversional activities, offering food or fluids, redirecting if near an exit door or offering to call the resident's family for him/her, as per the care plan.

Interview with SRNA #2 on 07/29/15 at 3:46 PM, revealed she observed Resident #1 on the night of 07/26/15 at the end of the 100 hall at approximately 7:25 PM. Per interview, she remembered Resident #1 asking if that was the way to go home which was common behavior for the resident. She stated on the night of 07/26/15, she recalled directing Resident #1 to the nurse's station; however, was unaware whether or not staff there had offered any further redirection or intervention, to include the care plan interventions.

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Interview with Licensed Practical Nurse (LPN) #1 on 07/29/15 at 6:40 PM, revealed she worked the evening of 07/26/15. LPN #1 stated she recalled seeing Resident #1 looking out the facility's patio door in the dining room at 7:30 PM, when she came to take another resident back to his/her room to administer medications. LPN #1 revealed she did not observe any unusual behavior, as Resident #1 would regularly look outside when up and about in his/her wheelchair.

Interview with the Director of Nursing (DON) on 07/31/15 at 5:40 PM and at 1:15 PM, revealed she expected her staff to be aware of where the residents were at all times. Continued interview revealed she expected residents care plan interventions to be appropriate and expected her staff to follow the residents' care plans.

Interview with the Administrator on 07/31/15 at 5:45 PM, revealed if a wandering resident was indicating a desire to leave the facility, the expectation was for all staff to be made aware of that information, and then monitor the wandering resident very closely.

The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/31/15, that alleged removal of the Immediate Jeopardy (IJ) effective 07/28/15. Review of the AOC revealed the facility implemented the following:

1. On 07/26/15, Resident #1 was immediately assessed by two (2) licensed nurses, LPN #1 and RN #1, and was found to have a small Hematoma to the right side of the forehead measuring 2.5 centimeters (cm) cm by 3.0 cm. Resident#1 was transported to the Emergency

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Room (ER)for evaluation and returned on 07/27/15, with diagnoses which include a large right frontotemporal scalp (forehead) Hematoma and a Urinary Tract Infection (UTI). Upon return to the facility, the resident was placed on every fifteen (15) minute checks for a period of seventy-two (72) hours.

2. On 07/26/15, the DON conducted a resident head count, which was to be conducted daily thereafter by the DON, Charge Nurse, or Social Services Director (SSD) and documented on a Wander Precaution Log tool.

3. On 07/26/15, five (5) residents at risk for elopement had wanderguard bracelets in place. The placement and function was checked by the Restorative Nursing Assistant on that date. The Restorative Nursing Assistant, Assistant Director of Nursing (ADON), or DON checked the wanderguard bracelets daily for function and placement and documented results in the tracking log.

4. On 07/26/15, following the incident involving Resident #1, the door to the kitchen from the dining room was secured and locked. On the morning of 07/27/15, the door to the kitchen from the dining room lock was changed to a self-locking mechanism with a keypad by the Maintenance Director.

5. On 07/27/15, inservices were initiated for all facility staff regarding the key pad lock on the kitchen door and the process for monitoring door security. Employees were not allowed to return to work until inservices were completed. The facility does not employ agency staff.

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6. On 07/27/15, door security was to be validated daily by the Dietary Department employees and nursing employee utilizing door lock logs posted on the door to the kitchen. Those logs would be checked weekly by the Food Service Director and the Quality Assurance (QA) Nurse to ensure completion was occurring.

7. All residents were re-evaluated on 07/27/15, using the Wander/Elopement Risk Evaluation tool by the SSD, which was reviewed and compared to residents' Comprehensive Care Plan to ensure interventions were in place and appropriate. This review will continue monthly and will be completed by RN MDS Coordinator, SSD and the QA Nurse.

8. On 07/27/15, all resident Comprehensive Care Plans, including Resident #1's, were reviewed. No updates or changes were required except for Resident #1's related to the elopement incident on 07/26/15, with resulting injury.

9. On 07/27/15, an Elopement QA safety drill was conducted on second (2nd) shift to ensure staff's appropriate and timely response to a simulated elopement event, which was conducted by the SSD.

10. Beginning on 07/27/15, in-services were conducted for nursing staff, licensed and unlicensed, regarding care plans for residents' at risk for elopement. Employees not present for the inservice were not allowed to return until completion of the inservice. The facility does not employ agency staff.

11. Beginning 07/27/15, residents showing increased risk for elopement would have care

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plans interventions reviewed and updated daily as needed by licensed nurses. Also on 07/27/15, the facility implemented review of residents at risk for elopement Comprehensive Care Plans which will be re-evaluated daily, Monday through Friday, in the facility clinical stand up meeting by the IDT (Interdisciplinary Team) which consists of the DON, ADON, MDS Coordinator, QA Nurse, SSD and Activites Director to ensure all interventions are in place and appropriate.

12. The QA Committee met on 07/27/15, to review the plan of action and the results of all initiated audits and reviews. Ongoing monitoring will continue to be performed weekly by the QA Committee through review of completed audits, with changes implemented as needed.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Review of Resident #1's medical record and hospital ER Radiology Reports confirmed Resident #1 was sent to the ER on 07/26/15 and did not return until 07/27/15. Review of Radiology Reports dated 07/27/15 verified Resident #1 was diagnosed with a large right frontotemporal scalp (forehead) Hematoma and UTI while in the ER. Continued record review revealed Resident Monitoring Logs which noted every fifteen (15) minute checks were completed for Resident #1 initiated on 07/27/15 at 1:45 AM, the time of the resident's return to the facility from the hospital ER. Continued review of the Resident Monitoring Logs revealed the every fifteen (15) minute checks were completed daily and still ongoing at the time of the survey on 07/31/15. Additionally, record review revealed Resident #1 had neurological (neuro) checks initiated on 07/27/15

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at 1:45 AM which were completed every fifteen (15) minutes for one (1) hour, every thirty (30) minutes for one (1) hour, hourly checks for four (4) hours and every four (4) hour checks times twenty-four (24) hours. Review of Resident #1's Physician's Orders revealed the neuro checks were discontinued on 07/29/15 at 5:00 PM.

Interview with LPN #1 on 07/29/15 at 6:40 PM and RN #1 on 07/30/15 at 8:57, verified they were the licensed nursing staff working the evening of 07/26/15 at 7:35 PM, who assessed Resident #1 when the resident was discovered lying on the sidewalk outside the dietary exit.

2. Review of the facility's Initial Resident Count for Wandering Precautions revealed as of 07/31/15, fourteen (14) resident head counts had been performed at various times of the day and night across all shifts, beginning on 07/26/15 at 8:00 PM by the DON and were continuing at the time of survey exit.

Interview, on 07/31/15 at 5:01 PM, with the DON revealed resident head counts continued at the time, as per the AOC.

3. Review of the facility's audit documentation revealed on 07/26/15, audits were initiated on five (5) residents at risk for elopement who had wanderguard bracelets in place. Review of the audit documentation revealed the placement and function of the wanderguards was checked by the Restorative Nursing Assistant, ADON or DON. Review of the facility's Code Alert Daily Bracelet Check audit documentation revealed all residents' at risk for elopement who had wanderguard bracelets had their bracelets checked daily by staff for July 2015.

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Interview with the ADON on 07/31/15 at 5:20 PM, revealed the same device used to check the functioning of wanderguard bracelets was also used to check the functioning of exit doors. In addition, to checking for functioning and placement, the ADON stated wanderguard bracelets were also checked for expiration date to ensure they were replaced prior to expiration.

Interview with the DON on 07/31/15 at 5:01 PM, revealed audits were conducted via the Code Alert Daily Bracelet Check beginning 07/27/15, with no concerns identified at the time.

4. Interview with the DON on 07/30/15 at 1:15 PM, revealed she had ensured the kitchen door was locked following the incident the night of 07/26/15. The DON stated the morning of 07/27/15, between 10:00 AM and 10:30 AM, the kitchen door lock was changed and a key pad lock was installed on the door leading to the kitchen from the dining room.

Observation, on 07/31/15 at 5:10 PM, by the Surveyor, revealed a keypad lock was in place and the door could not be opened without punching in the correct code for the keypad.

5. Review of the facility's AOC validation documentation revealed beginning on 07/27/15, inservices were conducted for all staff regarding the keypad lock and the process for monitoring door security.

Interview with LPN #1 on 07/29/15 at 6:40 PM and on 07/30/15 at 2:48 PM with LPN #2, at 3:16 PM with SRNA #5 and at 3:26 PM with SRNA #1 revealed they had all received inservice education

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regarding the newly installed keypad door lock on the door leading to the kitchen from the dining room. Per interview, staff was to sign in on a log if entering the kitchen after dietary staff had exited, and was responsible for ensuring the kitchen door was closed and secured upon exit.

Interview on 07/30/15 at 1:40 PM, with the Staffing Development Coordinator (SDC) revealed facility staff had been educated on the new keypad lock and their responsibility regarding monitoring the kitchen door's security, as per the AOC.

6. Review of the facility's AOC validation documentation revealed a Dietary Department Door Monitoring Log which had been initiated on 07/27/15, and had been completed by dietary and nursing staff through the date of the survey, 07/31/15.

Interview with the QA Nurse on 07/30/14 at 1:40 PM, revealed staff entering the kitchen after hours were expected to sign the Dietary Department Door Monitoring Log indicating they had ensured the door was secured upon exiting the kitchen area. She stated the log was being reviewed daily during IDT meeting to ensure staff were utilizing and completing the log correctly, with no discrepancies noted so far.

7. Review of the facility's AOC validation documentation revealed the SSD had completed a re-evaluation of all fifty (50) facility residents on 07/27/15 using the Wander/Elopement Risk Evaluation tool.

Interview with the SSD on 07/30/15 at 3:45 PM, revealed she completed the Wander/Elopement

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Risk Evaluation tool for all fifty (50) residents on 07/27/15, with no additional residents identified as an elopement risk. The SSD stated the facility planned for re-evaluations to be completed at least monthly for the next quarter.

8. Review of the eight (8) residents', some of who were at risk for elopement, (Resident #1, Resident #2, Resident #3, and Unsampled Residents A, B, C, and D) Comprehensive Care Plans revealed Resident #1's care plan had been the only one (1) which required update/revision following the incident on 07/26/15, and after the SSD re-evaluation on 07/27/15.

Interview with the SSD on 07/30/15 at 3:45 PM, revealed only Resident #1's Comprehensive Care Plan required updating/revising after the incident on 07/26/15, and after completion of the re-evaluation for elopement risk on 07/27/15.

Interview with the MDS Coordinator on 07/30/15 at 3:58 PM, revealed all residents' Comprehensive Care Plans were reviewed on 07/27/15 to ensure there were no discrepancies regarding resident elopement risk, and only Resident #1's care plan required updating as a result of the incident on 07/26/15.

9. Review of the facility's AOC validation documentation revealed an Elopement Drill Report dated 07/27/15, which noted a simulated elopement was initiated at 4:18 PM, on an unsampled resident not identified as an elopement risk. Sixteen (16) staff were present at the time of the drill and participated in the drill, with the simulated unsampled resident being located at 4:20 PM.

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Interview with the SSD on 07/30/15 at 3:45 PM, revealed an Elopement Drill was performed on 07/27/15, as per the AOC. The SSD stated drills would continue to be conducted quarterly on each shift at different times to ensure a variety of staff participated. Per interview, the SSD considered the 07/27/15 drill successful as all staff participated and the identified resident was located within minutes of the code being announced. The SSD stated the facility performed elopement drills prior to the incident on 07/26/15 involving Resident #1.

10. Review of the facility's AOC validation documentation revealed an in-service was provided for licensed and non-licensed nursing staff regarding residents' at risk for elopement and their care plans. Review revealed the inservices were initiated on 07/27/15, with staff not being permitted to return to work until completion of the elopement inservice.

Interview on 07/29/15 at 6:40 PM with LPN #1; at 6:48 PM, with SRNA #3; at 6:50 PM, with SRNA #4; and on 07/30/15 at 2:45 PM with SRNA #1; at 2:48 PM, with LPN #2; at 3:46 PM, with SRNA #2; at 3:16 PM, with SRNA #5; at 9:02 PM, with SRNA #6; at 3:04 PM, with LPN #3; and at 8:57 PM, with RN #1 revealed they had all received inservice education regarding residents' identified at risk for elopement and ensuring they followed their care plans.

Interview, on 07/30/15 at 1:40 PM, with the SDC revealed she had provided inservice education for nursing staff regarding residents at risk for elopement and ensuring their care plans were followed beginning on 07/27/15, with all staff currently having received the inservice education.

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Interview, on 07/30/15 at 3:45 PM, with the SSD revealed she had assisted in providing the inservice education for staff related to residents identified at risk for elopement and ensuring their care plans were followed.

11. Interview with LPN #1 on 07/29/15 at 6:40 PM and on 07/30/15 at 2:48 PM with LPN #2; at 3:04 PM, with LPN #3; and at 8:57 PM, with RN #1 revealed they had all been educated regarding reviewing residents at risk for elopement care plans to ensure the care plans remained effective and/or to initiate new interventions as necessary. The nurses stated they would review and update residents' care plans as necessary.

Interview, on 07/31/15 at 5:01 PM, with the DON revealed daily in the facility's IDT meetings, all resident incidents were discussed and a root cause analysis performed. The DON stated in the IDT meeting residents involved in any incidents care plans were reviewed and updated as necessary. Per interview, the facility currently had a process in place to review resident Wander/Elopement Evaluation tools and compare them to the residents' Comprehensive Care Plans daily to ensure interventions were both in place and appropriate, as per the AOC.

12. Review of the facility's outline for the Quality Assurance (QA) meeting held on 07/27/15, revealed the incident involving Resident #1's elopement on 07/26/15, was the main topic listed for discussion. Further review revealed the QA Committee reviewed the their plan of action and approved it.

Interview, on 07/31/15 at 5:01 PM, with the DON

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F 282	Continued From page 15 revealed on 07/27/15 a QA meeting was held in which the facility's AOC was discussed in detail and approved by the QA Committee members present. The DON stated the facility's Medical Director was notified of the incident involving Resident #1, of the facility's AOC which he approved. Interview with the Administrator on 07/31/15 at 5:45 PM revealed the facility had implemented all actions identified in the AOC and the facility felt as a result of the implementation of the AOC the Immediate Jeopardy (IJ) had been removed before the current survey was initiated.	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and incident report, it was determined the facility failed to have an effective system in place to ensure adequate supervision and monitoring for one (1) of three (3) sampled residents (Resident #1) whom the facility assessed to have wandering behaviors. On 07/26/15, Resident #1 exited the facility between 7:30 PM and 7:35 PM, without staff's	F 323	Past noncompliance: no plan of correction required.	

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knowledge. Per staff interview, Resident #1 had been making statements about going home and attempting to exit through one of the hallway doors prior to his/her successful elopement. Resident #1 wheeled his/her wheelchair into the facility's kitchen where he/she proceeded to disconnect the tab alarm. Resident #1 stood up from the wheelchair and ambulated independently for approximately twenty (20) feet before leaving the facility through the kitchen door. Resident #1 experienced a fall onto the sidewalk outside the kitchen exit door and was heard calling out "help me", by a staff person who had exited the facility for break at approximately 7:35 PM. The staff person went into the facility and notified nursing staff of Resident #1 lying on the sidewalk outside the kitchen door. Resident #1 was transported to the hospital emergency room (ER) by emergency medical staff (EMS) staff and was diagnosed with a large Hematoma on his/her right forehead. Resident #1 returned to the facility the morning of 07/27/15.

The facility's failure to have an effective system in place to provide supervision and monitoring has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 07/30/15 and was determined to exist on 07/26/15. The facility was notified of the Immediate Jeopardy on 07/30/15.

The facility provided an acceptable credible Allegation of Compliance (AOC) on 07/31/15, alleging removal of the Immediate Jeopardy on 07/28/15. Based on the validation of the AOC, the State Survey Agency determined the deficient practice was corrected on 07/28/15, prior to the initiation of the investigation; therefore, it was determined to be Past Immediate Jeopardy.

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The findings include:

Review of the facility's policy titled, "Elopement," undated, revealed elopement was defined as an "unauthorized" leaving of the facility's premises by a resident who was missing or incapable of making sound judgements regarding their safety. The Policy revealed should an elopement occur it was an emergency situation and a "Code Purple" was to be called three (3) consecutive times on the overhead paging system. According to the Policy, staff was to notify the Administrator and Director of Nursing (DON) and if the resident was not found the resident's family, Physician, and local emergency services would be contacted for help. Per the Policy, the facility took a "pro-active approach towards protecting all residents" and took precautions to "avoid elopement by any resident".

Review of Resident #1's medical record revealed the facility admitted the resident on 04/02/14, with diagnoses which included Depressive Disorder, and Insomnia. Review of the 05/11/15 Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), which indicated the resident was severely cognitively impaired. Further review of the MDS Assessment revealed the facility assessed Resident #1 as having wandering behavior which occurred four (4) to six (6) days, but not daily.

Review of Resident #1's Comprehensive Care Plan revealed the facility had care planned Resident #1 as at risk for elopement. Review of the elopement care plan, dated 05/11/15,

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revealed interventions which included: engaging Resident #1 in diversional activities when wandering or talking about leaving the facility; ensuring wanderguard alarm was working and in place; redirecting Resident #1 when wandering near an exit door; offering food and fluids; and offering to "notify" Resident #1's family.

Review of the facility's "Initial and Final Report" dated 07/27/15, regarding an incident involving Resident #1, revealed the resident exited the facility through the Dietary Department exterior door on 07/26/15. Continued review revealed Resident #1 suffered a fall with injury on the sidewalk outside the dietary exit door between 7:30 PM and 7:35 PM, when the resident was discovered.

Continued record review revealed a Nurse's Note dated 07/26/15 at 7:35 PM, documented by Registered Nurse (RN) #1, which noted Resident #1 was found lying on the left side on the sidewalk with a purse observed under his/her head. The Nurse's Note revealed Resident #1's vital signs were taken and the resident was assessed to have a "large Hematoma" observed on the right forehead area which had a "dark purple discoloration with top layer abrasion and small amount of blood". Continued review of the Nurse's Note revealed Resident #1 complained of head, neck, lower back, right sided groin and bilateral knee pain rated on a scale of one (1) to ten (10) as an eight (8). Per the Nurse's Note, 911 was notified and Resident #1's wheelchair was found inside the facility's kitchen area with the brakes unlocked and tab alarm on the wheelchair. Review of the Nurse's Note dated 07/26/15 at 45 PM, revealed EMS personnel had arrived and Resident #1 was being transported to

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the hospital ER, after placement of a cervical collar (c-collar) and immobilization on a back board.

Review of the hospital Radiology Reports dated 07/27/15, revealed Resident #1 had Computerized Tomography (CT) scans of the head, pelvis and abdomen which were negative for fracture. Continued review revealed Resident #1 had a large right frontotemporal scalp (forehead) Hematoma and contusion.

Interview with State Registered Nursing Assistant (SRNA) #4 on 07/29/15 at 6:50 PM, revealed she worked on 07/26/15, on the 200 Hall, the hall on which Resident #1 resided. She stated she was one (1) of two (2) assigned SRNAs on the 200 hall that night. Per interview, on the facility's 6:30 PM to 7:00 AM shift, the SRNAs were not assigned to specific residents and just worked together on the hall to meet residents' care needs. SRNA #4 stated on 07/26/15, she had observed Resident #1 wandering up and down the hallways in his/her wheelchair. Continued interview revealed SRNA #4 had heard Resident #1 making comments related to wanting to go home on that day and also on the previous day, 07/25/15. The SRNA reported, when staff observed those behaviors in Resident #1 they were to redirect Resident #1 by talking about things the resident liked and giving him/her tasks to perform to occupy the resident's time. However, interview revealed SRNA #4 was unable to recall if those interventions were attempted on 07/26/15.

Interview, on 07/30/15 at 9:02 PM, with SRNA #6 revealed she worked the 200 hall the evening of 07/26/15. SRNA #6 revealed she observed

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Resident #1 wheeling his/her wheelchair up and down the hallways that evening. She stated she last saw Resident #1 sometime between 7:20 PM and 7:30 PM, when she observed the resident watching television with another resident in that resident's room.

Interview, on 07/29/15 at 3:46 PM, with SRNA #2 revealed she observed Resident #1 on 07/26/15, at the end of the 100 hall at approximately 7:25 PM. Per interview, she remembered Resident #1 asking if that was the way to go home. According to SRNA #2, Resident #1 wanting to go home and asking about going home were a common occurrence. SRNA #2 revealed she recalled directing Resident #1 to the nurse's station the evening of 07/26/15; however she was not aware of what occurred after doing so.

Interview with SRNA #1 on 07/29/15 at 2:37 PM, revealed she was working the 100 hall on the evening of 07/26/15, and had observed Resident #1 wandering around during most of the evening. SRNA #1 revealed she came in to work at 2:30 PM on 07/26/15, and observed Resident #1 up in his/her wheelchair after dinner. SRNA #1 stated she left the facility for her "lunch" break at 7:35 PM through the patio exit, and heard someone nearby calling out "help me". Continued interview revealed she walked around towards the kitchen exit, at which point she observed Resident #1 lying on the sidewalk on his/her left side with his/her head resting on a purse. SRNA #1 stated she ran back into the facility to alert nursing staff at that time, and several staff rushed out to assist Resident #1.

Interview with Licensed Practical Nurse (LPN) #1 on 07/29/15 at 6:40 PM, revealed she worked the

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evening of 07/26/15, and recalled seeing Resident #1 looking out the patio door in the dining room at 7:30 PM, when she came to take another resident back to his/her room to pass medications. LPN #1 revealed she did not observe any unusual behavior, as Resident #1 would regularly look outside when up and about in his/her wheelchair. Continued interview revealed she was finishing up her medication (med) pass on the 100 hall on 07/26/15, when SRNA #1 alerted her Resident #1 was outside. LPN #1 revealed Resident #1 was lying on his/her left side, with his/her head resting on a purse, with a small Hematoma to the right side of the forehead. She stated Resident #1 was complaining of neck, back and leg pain and asking about his/her car keys. LPN #1 revealed due to Resident #1's complaints of pain the resident was not moved by facility staff, and an immediate call was placed to 911. LPN #1 revealed EMS was at the facility and transporting Resident #1 to the hospital ER within five (5) minutes of making the 911 call.

Interview, on 07/31/15 at 5:40 PM, with the DON revealed her expectation was residents would not be allowed to exit the building without staff knowledge, and the facility had safety measures in place to prevent resident elopement. The DON stated her expectation was for the staff to be aware of the location of residents at all times, with a focus on wanderers and the prevention of elopement.

Interview with the Administrator on 07/31/15 at 5:45 PM, revealed he had only been in the position for two (2) weeks. The Administrator stated in his opinion the elopement of Resident #1 was a "aberration", (an unusual or rare

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occurrence), as the facility had security systems in place on all the doors so residents could not get out. However, the door between the dining room and the kitchen was kept unlocked prior to the elopement and the exit door in the kitchen was not alarmed. Continued interview revealed the facility's residents were "monitored regularly", and Resident #1's elopement was not reflective of the attention normally afforded facility residents. The Administrator stated he was unaware of any previous concerns regarding elopement, and preventive measures had been adequate until the current incident involving Resident #1. Per interview, the expectation was facility staff would be attentive to residents' actions and statements, and ensure residents showing a desire to leave the facility or attempting to do so were monitored more closely.

The facility provided an acceptable Credible Allegation of Compliance (AOC) on 07/31/15, that alleged removal of the Immediate Jeopardy (IJ) effective 07/28/15. Review of the AOC revealed the facility implemented the following:

1. On 07/26/15, Resident #1 was immediately assessed by two (2) licensed nurses, LPN #1 and RN #1, and was found to have a small Hematoma to the right side of the forehead measuring 2.5 centimeters (cm) cm by 3.0 cm. Resident#1 was transported to the Emergency Room (ER)for evaluation and returned on 07/27/15, with diagnoses which include a large right frontotemporal scalp (forehead) Hematoma and a Urinary Tract Infection (UTI). Upon return to the facility, the resident was placed on every fifteen (15) minute checks for a period of seventy-two (72) hours.

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2. On 07/26/15, the DON conducted a resident head count, which was to be conducted daily thereafter by the DON, Charge Nurse, or Social Services Director (SSD) and documented on a Wander Precaution Log tool.

3. On 07/26/15, five (5) residents at risk for elopement had wanderguard bracelets in place. The placement and function was checked by the Restorative Nursing Assistant on that date. The Restorative Nursing Assistant, Assistant Director of Nursing (ADON), or DON checked the wanderguard bracelets daily for function and placement and documented results in the tracking log.

4. On 07/26/15, following the incident involving Resident #1, the door to the kitchen from the dining room was secured and locked. On the morning of 07/27/15, the door to the kitchen from the dining room lock was changed to a self-locking mechanism with a keypad by the Maintenance Director.

5. On 07/27/15, inservices were initiated for all facility staff regarding the key pad lock on the kitchen door and the process for monitoring door security. Employees were not allowed to return to work until inservices were completed. The facility does not employ agency staff.

6. On 07/27/15, door security was to be validated daily by the Dietary Department employees and nursing employee utilizing door lock logs posted on the door to the kitchen. Those logs would be checked weekly by the Food Service Director and the Quality Assurance (QA) Nurse to ensure completion was occurring.

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7. All residents were re-evaluated on 07/27/15, using the Wander/Elopement Risk Evaluation tool by the SSD, which was reviewed and compared to residents' Comprehensive Care Plan to ensure interventions were in place and appropriate. This review will continue monthly and will be completed by RN MDS Coordinator, SSD and the QA Nurse.

8. On 07/27/15, all resident Comprehensive Care Plans, including Resident #1's, were reviewed. No updates or changes were required except for Resident #1's related to the elopement incident on 07/26/15, with resulting injury.

9. On 07/27/15, an Elopement QA safety drill was conducted on second (2nd) shift to ensure staff's appropriate and timely response to a simulated elopement event, which was conducted by the SSD.

10. Beginning on 07/27/15, in-services were conducted for nursing staff, licensed and unlicensed, regarding care plans for residents' at risk for elopement. Employees not present for the inservice were not allowed to return until completion of the inservice. The facility does not employ agency staff.

11. Beginning 07/27/15, residents showing increased risk for elopement would have care plans interventions reviewed and updated daily as needed by licensed nurses. Also on 07/27/15, the facility implemented review of residents at risk for elopement Comprehensive Care Plans which will be re-evaluated daily, Monday through Friday, in the facility clinical stand up meeting by the IDT (Interdisciplinary Team) which consists of the DON, ADON, MDS Coordinator, QA Nurse, SSD

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and Activities Director to ensure all interventions are in place and appropriate.

12. The QA Committee met on 07/27/15, to review the plan of action and the results of all initiated audits and reviews. Ongoing monitoring will continue to be performed weekly by the QA Committee through review of completed audits, with changes implemented as needed.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Review of Resident #1's medical record and hospital ER Radiology Reports confirmed Resident #1 was sent to the ER on 07/26/15 and did not return until 07/27/15. Review of Radiology Reports dated 07/27/15 verified Resident #1 was diagnosed with a large right frontotemporal scalp (forehead) Hematoma and UTI while in the ER. Continued record review revealed Resident Monitoring Logs which noted every fifteen (15) minute checks were completed for Resident #1 initiated on 07/27/15 at 1:45 AM, the time of the resident's return to the facility from the hospital ER. Continued review of the Resident Monitoring Logs revealed the every fifteen (15) minute checks were completed daily and still ongoing at the time of the survey on 07/31/15. Additionally, record review revealed Resident #1 had neurological (neuro) checks initiated on 07/27/15 at 1:45 AM which were completed every fifteen (15) minutes for one (1) hour, every thirty (30) minutes for one (1) hour, hourly checks for four (4) hours and every four (4) hour checks times twenty-four (24) hours. Review of Resident #1's Physician's Orders revealed the neuro checks were discontinued on 07/29/15 at 5:00 PM.

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Interview with LPN #1 on 07/29/15 at 6:40 PM and RN #1 on 07/30/15 at 8:57, verified they were the licensed nursing staff working the evening of 07/26/15 at 7:35 PM, who assessed Resident #1 when the resident was discovered lying on the sidewalk outside the dietary exit.

2. Review of the facility's Initial Resident Count for Wandering Precautions revealed as of 07/31/15, fourteen (14) resident head counts had been performed at various times of the day and night across all shifts, beginning on 07/26/15 at 8:00 PM by the DON and were continuing at the time of survey exit.

Interview, on 07/31/15 at 5:01 PM, with the DON revealed resident head counts continued at the time, as per the AOC.

3. Review of the facility's audit documentation revealed on 07/26/15, audits were initiated on five (5) residents at risk for elopement who had wanderguard bracelets in place. Review of the audit documentation revealed the placement and function of the wanderguards was checked by the Restorative Nursing Assistant, ADON or DON. Review of the facility's Code Alert Daily Bracelet Check audit documentation revealed all residents' at risk for elopement who had wanderguard bracelets had their bracelets checked daily by staff for July 2015.

Interview with the ADON on 07/31/15 at 5:20 PM, revealed the same device used to check the functioning of wanderguard bracelets was also used to check the functioning of exit doors. In addition, to checking for functioning and placement, the ADON stated wanderguard bracelets were also checked for expiration date to

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ensure they were replaced prior to expiration.

Interview with the DON on 07/31/15 at 5:01 PM, revealed audits were conducted via the Code Alert Daily Bracelet Check beginning 07/27/15, with no concerns identified at the time.

4. Interview with the DON on 07/30/15 at 1:15 PM, revealed she had ensured the kitchen door was locked following the incident the night of 07/26/15. The DON stated the morning of 07/27/15, between 10:00 AM and 10:30 AM, the kitchen door lock was changed and a key pad lock was installed on the door leading to the kitchen from the dining room.

Observation, on 07/31/15 at 5:10 PM, by the Surveyor, revealed a keypad lock was in place and the door could not be opened without punching in the correct code for the keypad.

5. Review of the facility's AOC validation documentation revealed beginning on 07/27/15, inservices were conducted for all staff regarding the keypad lock and the process for monitoring door security.

Interview with LPN #1 on 07/29/15 at 6:40 PM and on 07/30/15 at 2:48 PM with LPN #2, at 3:16 PM with SRNA #5 and at 3:26 PM with SRNA #1 revealed they had all received inservice education regarding the newly installed keypad door lock on the door leading to the kitchen from the dining room. Per interview, staff was to sign in on a log if entering the kitchen after dietary staff had exited, and was responsible for ensuring the kitchen door was closed and secured upon exit.

Interview on 07/30/15 at 1:40 PM, with the

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Staffing Development Coordinator (SDC) revealed facility staff had been educated on the new keypad lock and their responsibility regarding monitoring the kitchen door's security, as per the AOC.

6. Review of the facility's AOC validation documentation revealed a Dietary Department Door Monitoring Log which had been initiated on 07/27/15, and had been completed by dietary and nursing staff through the date of the survey, 07/31/15.

Interview with the QA Nurse on 07/30/14 at 1:40 PM, revealed staff entering the kitchen after hours were expected to sign the Dietary Department Door Monitoring Log indicating they had ensured the door was secured upon exiting the kitchen area. She stated the log was being reviewed daily during IDT meeting to ensure staff were utilizing and completing the log correctly, with no discrepancies noted so far.

7. Review of the facility's AOC validation documentation revealed the SSD had completed a re-evaluation of all fifty (50) facility residents on 07/27/15 using the Wander/Elopement Risk Evaluation tool.

Interview with the SSD on 07/30/15 at 3:45 PM, revealed she completed the Wander/Elopement Risk Evaluation tool for all fifty (50) residents on 07/27/15, with no additional residents identified as an elopement risk. The SSD stated the facility planned for re-evaluations to be completed at least monthly for the next quarter.

8. Review of the eight (8) residents', some of who were at risk for elopement, (Resident #1,

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Resident #2, Resident #3, and Unsampled Residents A, B, C, and D) Comprehensive Care Plans revealed Resident #1's care plan had been the only one (1) which required update/revision following the incident on 07/26/15, and after the SSD re-evaluation on 07/27/15.

Interview with the SSD on 07/30/15 at 3:45 PM, revealed only Resident #1's Comprehensive Care Plan required updating/revising after the incident on 07/26/15, and after completion of the re-evaluation for elopement risk on 07/27/15.

Interview with the MDS Coordinator on 07/30/15 at 3:58 PM, revealed all residents' Comprehensive Care Plans were reviewed on 07/27/15 to ensure there were no discrepancies regarding resident elopement risk, and only Resident #1's care plan required updating as a result of the incident on 07/26/15.

9. Review of the facility's AOC validation documentation revealed an Elopement Drill Report dated 07/27/15, which noted a simulated elopement was initiated at 4:18 PM, on an unsampled resident not identified as an elopement risk. Sixteen (16) staff were present at the time of the drill and participated in the drill, with the simulated unsampled resident being located at 4:20 PM.

Interview with the SSD on 07/30/15 at 3:45 PM, revealed an Elopement Drill was performed on 07/27/15, as per the AOC. The SSD stated drills would continue to be conducted quarterly on each shift at different times to ensure a variety of staff participated. Per interview, the SSD considered the 07/27/15 drill successful as all staff participated and the identified resident was

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located within minutes of the code being announced. The SSD stated the facility performed elopement drills prior to the incident on 07/26/15 involving Resident #1.

10. Review of the facility's AOC validation documentation revealed an in-service was provided for licensed and non-licensed nursing staff regarding residents' at risk for elopement and their care plans. Review revealed the inservices were initiated on 07/27/15, with staff not being permitted to return to work until completion of the elopement inservice.

Interview on 07/29/15 at 6:40 PM with LPN #1; at 6:48 PM, with SRNA #3; at 6:50 PM, with SRNA #4; and on 07/30/15 at 2:45 PM with SRNA #1; at 2:48 PM, with LPN #2; at 3:46 PM, with SRNA #2; at 3:16 PM, with SRNA #5; at 9:02 PM, with SRNA #6; at 3:04 PM, with LPN #3; and at 8:57 PM, with RN #1 revealed they had all received inservice education regarding residents' identified at risk for elopement and ensuring they followed their care plans.

Interview, on 07/30/15 at 1:40 PM, with the SDC revealed she had provided inservice education for nursing staff regarding residents at risk for elopement and ensuring their care plans were followed beginning on 07/27/15, with all staff currently having received the inservice education.

Interview, on 07/30/15 at 3:45 PM, with the SSD revealed she had assisted in providing the inservice education for staff related to residents identified at risk for elopement and ensuring their care plans were followed.

11. Interview with LPN #1 on 07/29/15 at 6:40

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PM and on 07/30/15 at 2:48 PM with LPN #2; at 3:04 PM, with LPN #3; and at 8:57 PM, with RN #1 revealed they had all been educated regarding reviewing residents at risk for elopement care plans to ensure the care plans remained effective and/or to initiate new interventions as necessary. The nurses stated they would review and update residents' care plans as necessary.

Interview, on 07/31/15 at 5:01 PM, with the DON revealed daily in the facility's IDT meetings, all resident incidents were discussed and a root cause analysis performed. The DON stated in the IDT meeting residents involved in any incidents care plans were reviewed and updated as necessary. Per interview, the facility currently had a process in place to review resident Wander/Elopement Evaluation tools and compare them to the residents' Comprehensive Care Plans daily to ensure interventions were both in place and appropriate, as per the AOC.

12. Review of the facility's outline for the Quality Assurance (QA) meeting held on 07/27/15, revealed the incident involving Resident #1's elopement on 07/26/15, was the main topic listed for discussion. Further review revealed the QA Committee reviewed the plan of action and approved it.

Interview, on 07/31/15 at 5:01 PM, with the DON revealed on 07/27/15 a QA meeting was held in which the facility's AOC was discussed in detail and approved by the QA Committee members present. The DON stated the facility's Medical Director was notified of the incident involving Resident #1, of the facility's AOC which he approved.

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F 323	Continued From page 32 Interview with the Administrator on 07/31/15 at 5:45 PM revealed the facility had implemented all actions identified in the AOC and the facility felt as a result of the implementation of the AOC the Immediate Jeopardy (IJ) had been removed before the current survey was initiated.	F 323		